## PATIENT INFORMATION

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Age: ____ Gender or Orientation: _____

Address: _____ City_____ State: ____ Zip: _____

Occupation: _____ Name of Employer: _____

Marital Status: _____If married, Name of Spouse: _____

**I Authorize Blue Spark Health, PLLC to contact me at the following:**

Home phone: _____Leave message at home: Yes: ☐ No: ☐

Mobile: _____ Leave message on mobile: Yes: ☐ No: ☐

Work Phone: _____ Leave message at office: Yes: ☐ No: ☐

Email address: _____

_____ Initials

## EMERGENCY CONTACT

Emergency Contact Name: _____Relationship: _____

Emergency Contact Phone Number (s): _____ / _____

Name of Primary Care Doctor: _____

Names of Specialists: _____

## INSURANCE INFORMATION

Name of Insurance Company: _____

Name of Insured: _____ Date of Birth: _____

Whom may we thank for referring you to Blue Spark Health? _____

**SYMPTOM SURVEY**

Name: _____ Date: _____

What are your 3 primary health concerns/health goals in order of importance?

1. _____
2. _____
3. _____

Have you received other treatment for these conditions? If Yes, what, when, where?

_____

_____

_____

What are your hopes and expectations from treatment with Dr. Phillips?

_____

_____

_____

**PLEASE CHECK AND/OR CIRCLE ANY SYMPTOMS THAT APPLY TO YOU ON THE FOLLOWING PAGES**

| NOW | PAST | GENERAL SYMPTOMS |
|---|---|---|
| ☐ | ☐ | Tired, weak, lack of energy |
| ☐ | ☐ | Depression, melancholy, moodiness |
| ☐ | ☐ | Worry, anxiety, nervousness, irritability |
| ☐ | ☐ | Difficulty with sleep |
| ☐ | ☐ | Frequent colds or other illness |
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Don't sweat enough |
| ☐ | ☐ | Sweat too much |
| ☐ | ☐ | Night sweats |
| ☐ | ☐ | Dizziness, fainting, convulsions |
| ☐ | ☐ | Loss or gain of weight |
| | | |
| **Other:** | | |

| NOW | PAST | SKIN AND HAIR |
|---|---|---|
| ☐ | ☐ | Acne or pimples |
| ☐ | ☐ | Skin rashes |
| ☐ | ☐ | Hives |
| ☐ | ☐ | Stretch marks |
| ☐ | ☐ | Skin ulcers or sores |
| ☐ | ☐ | Dryness, roughness or scaling skin |
| ☐ | ☐ | Hair loss or thinning |
| ☐ | ☐ | Dry, coarse hair or split ends |
| ☐ | ☐ | Bruise easily |
| ☐ | ☐ | Nails weak, ridged or split easily |
| ☐ | ☐ | Brown spots or bronzing skin |
| ☐ | ☐ | Moles, warts, or skin tags |
| ☐ | ☐ | Sunburn easily |
| ☐ | ☐ | Cuts heal slowly or scar badly |
| ☐ | ☐ | Flush easily |
| ☐ | ☐ | Feet burn |
| ☐ | ☐ | Athletes foot |
| **Other:** | | |

| NOW | PAST | RESPIRATORY |
|---|---|---|
| ☐ | ☐ | Spitting up mucus or blood |
| ☐ | ☐ | Difficulty breathing |
| ☐ | ☐ | Shortness of breath on exertion |
| ☐ | ☐ | Shortness of breath laying flat |
| | | |
| **Other:** | | |

| NOW | PAST | EYES |
|---|---|---|
| ☐ | ☐ | nearsightedness or farsightedness |
| ☐ | ☐ | Blurred or failing vision |
| ☐ | ☐ | Dry, burning or itching eyes |
| ☐ | ☐ | Eyes water excessively |
| ☐ | ☐ | Eyes sensitive to light |
| ☐ | ☐ | Night blindness |
| ☐ | ☐ | Bloodshot or puffy eyes |
| Other: | | |

| NOW | PAST | EARS |
|---|---|---|
| ☐ | ☐ | Earaches |
| ☐ | ☐ | Noises or ringing in ears |
| ☐ | ☐ | Ear discharges |
| ☐ | ☐ | Loss of hearing |
| | | Lots of wax |
| | | |
| Other: | | |

| NOW | PAST | MOUTH, NOSE AND THROAT |
|---|---|---|
| ☐ | ☐ | Hay fever, sinusitis, runny nose |
| ☐ | ☐ | Cracks in corners of mouth |
| ☐ | ☐ | Dry mouth |
| ☐ | ☐ | Stuffy nose |
| ☐ | ☐ | Clear throat often |
| ☐ | ☐ | Sore, red or cracked tongue |
| ☐ | ☐ | Cold sores or herpes |
| ☐ | ☐ | Inability to smell or taste |
| ☐ | ☐ | Nose bleeds |
| ☐ | ☐ | Bleeding gums |
| ☐ | ☐ | Hoarseness |
| ☐ | ☐ | Sore throats or tonsillitis |
| ☐ | ☐ | Lot of cavities |
| ☐ | ☐ | Amalgam fillings |
| | | Root canals |
| **Other:** | | |

| NOW | PAST | MUSCULO-SKELETAL |
|---|---|---|
| ☐ | ☐ | Muscle pain or stiffness |
| ☐ | ☐ | Where? |
| ☐ | ☐ | Swollen, painful, or stiff joints |
| ☐ | ☐ | Bone pains |
| ☐ | ☐ | Painful feet, ankles or calves |

| NOW | PAST | GASTROINESTINAL | NOW | PAST | MUSCULO-SKELETAL |
|---|---|---|---|---|---|
| ☐ | ☐ | Loss of appetite | ☐ | ☐ | Tremor or twitches |
| ☐ | ☐ | Excessive appetite | ☐ | ☐ | Hernia |
| ☐ | ☐ | Gagging, difficulty swallowing | ☐ | ☐ | Muscle wasting |
| ☐ | ☐ | Nausea or vomiting | ☐ | ☐ | Hands or feet numb or tingling |
| ☐ | ☐ | Bad breath | **Other:** | | |
| ☐ | ☐ | Metallic or bitter taste in mouth | **NOW** | **PAST** | **CARDIOVASCULAR** |
| ☐ | ☐ | Food cravings or strong desires | ☐ | ☐ | Heart beats fast or irregularly |
| ☐ | ☐ | Can't eat fats | ☐ | ☐ | Tightness in chest |
| ☐ | ☐ | Heartburn | ☐ | ☐ | Dizzy or weak upon standing up |
| ☐ | ☐ | Indigestion or distress | ☐ | ☐ | Swollen feet, ankles or legs |
| ☐ | ☐ | Heaviness after eating | ☐ | ☐ | Discomfort at high altitude |
| ☐ | ☐ | Belching or gas | ☐ | ☐ | Cold hands or feet |
| ☐ | ☐ | Bloating | ☐ | ☐ | Hands or feet turn blue |
| ☐ | ☐ | Stomach or abdomen tender or painful | ☐ | ☐ | Blue fingernails |
| ☐ | ☐ | Symptoms relieved after eating | ☐ | ☐ | Leg pains when walking |
| ☐ | ☐ | Symptoms worse after eating | ☐ | ☐ | Varicose veins |
| ☐ | ☐ | Avoid certain foods | ☐ | ☐ | Tendency to anemia |
| ☐ | ☐ | If you skip a meal do you experience: | ☐ | ☐ | High blood pressure |
| ☐ | ☐ | Headache | ☐ | ☐ | Low blood pressure |
| ☐ | ☐ | Irritability or anxiety | **Other:** | | |
| ☐ | ☐ | Dizziness or fatigue | | | |
| ☐ | ☐ | Diarrhea or loose stools | **NOW** | **PAST** | **URINARY** |
| ☐ | ☐ | Constipation | ☐ | ☐ | Difficulty unration |
| ☐ | ☐ | Change in bowel movements | ☐ | ☐ | Urinate frequently at night |
| ☐ | ☐ | Light colored or greasy stools | ☐ | ☐ | Bed-wetting |
| ☐ | ☐ | Dark stools or blood in stool | ☐ | ☐ | Incomplete urination or dribbling |
| ☐ | ☐ | Feeling of incomplete evacuation | ☐ | ☐ | Pain when urinating |
| ☐ | ☐ | Undigested food in stool | ☐ | ☐ | Bladder infections |
| ☐ | ☐ | Foul odor of stool or gas | ☐ | ☐ | Kidney infections |
| ☐ | ☐ | Hemorrhoids | ☐ | ☐ | Kidney stones |
| **Other:** | | | ☐ | ☐ | Lower back pain |
| | | | **Other:** | | |
| **NOW** | **PAST** | **MALE** | **NOW** | **PAST** | **MALE** |
| ☐ | ☐ | Prostate problems | ☐ | ☐ | Difficulty obtaining or maintaining an erection |
| ☐ | ☐ | Difficult or unusual urination | **Other:** | | |
| ☐ | ☐ | Discomfort or pain in genital area | | | |
| ☐ | ☐ | Diminished sexual desire | | | |
| ☐ | ☐ | Excessive sexual desire | | | |

| NOW | PAST | FEMALE | NOW | PAST | FEMALE |
|---|---|---|---|---|---|
| ☐ | ☐ | Irregular menstruation | ☐ | ☐ | Hot flashes |
| ☐ | ☐ | Pain prior to or on periods | ☐ | ☐ | Diminished sexual desire |
| ☐ | ☐ | Depressed or irritable around periods | ☐ | ☐ | Excessive sexual desire |
| ☐ | ☐ | Painful or swollen breasts | ☐ | ☐ | Difficulty having orgasm |
| ☐ | ☐ | Lumps in breasts | ☐ | ☐ | Inability to conceive |
| ☐ | ☐ | Discharge from breasts | ☐ | ☐ | Number of pregnancies |
| ☐ | ☐ | Do symptoms occur monthly? | ☐ | ☐ | Miscarriages or abortions |
| ☐ | ☐ | NO ◉ YES ○ | | | |
| ☐ | ☐ | Pain discomfort or itching in genital area | Other: | | |
| ☐ | ☐ | Vaginal discharge | | | |

Date of last period_____ Number of days _____Length of cycle_____
Date of last PAP smear_____ Have you ever had an abnormal PAP_____
Have you ever used birth control pills or an IUD? NO YES If Yes what type and for how long? _____
Current type of birth control? _____

**GENERAL INFORMATION**

Do you get regular exercise? Yes ☐ No ☐ If Yes, what type? _____ How often? _____
Do you watch television? Yes ☐ No ☐ If Yes, hours per day _____ Week_____
Habits:
Tobacco Coffee Tea Soda Alcohol Cannabis Drugs Sugar Salt Other_____ How often_____
Average Daily Diet:
Morning: _____

Afternoon: _____

Evening : _____

| Is your Diet? | Mediterranean | Kosher | Vegetarian | Low Fat or No Fat | Gluten Free | Fast Food | Vegan | Organic | Macrobiotic |
|---|---|---|---|---|---|---|---|---|---|
| Please check | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Other Food Sensitivities
_____
**Do you have allergies? YES ☐ NO ☐**
Drugs: _____
_____
Foods: _____
_____
Environmental: _____
_____

| PRESCRIPTION MEDICINES AND OVER – THE-COUNTER MEDICATION<br>Please list any medications you are currently taking<br>(Use back of page if necessary) |
|---|
| |
| |
| |
| |
| |
| **VITAMINS, MINERALS, HERBS OR ANY NATURAL SUPPLEMENTS** |
| |
| |
| |
| |
| **Have you ever been hospitalized or had surgery, a serious illness or accident?**<br>**What? When?** |
| |
| |

**Have you or any of your family members had any of the problems in this chart?**
Please indicate who has had which problems by checking the appropriate space.

| | Self | Children | Mother | Father | Sister(s) | Brother(s) | Grandparents | Other |
|---|---|---|---|---|---|---|---|---|
| Thyroid Problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Tuberculosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Hypoglycemia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Heart Attack | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Epilepsy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Allergies | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Anemia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Migraines | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Hepatitis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Birth Defects | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| High blood pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Gallbladder Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Alcoholism/Addiction | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |